

Executive Summary

- Since the first confirmed cases of COVID-19 until epidemiological week (EW) 42 (ending 23 October 2021), 243,327,429 confirmed cumulative cases of COVID-19 have been reported globally, including 4,943,742 deaths, for which the Region of the Americas has contributed 38.2% of cases and 46.1% of deaths.
- The North America subregion continues accounting for the highest proportions of cases (76%) and deaths (72%) between EW) 38 and EW 42. In comparison with the previous 4-week period (EW 34-EW 37), the number of reported cases decreased across all sub-regions except for South America, where a 5.7% increase was observed. Comparing the same periods, the number of reported deaths increased in the North America (11.7%) and Central America (7.9%) subregions, while they decreased in the South America and the Caribbean and Atlantic Ocean Islands subregions.
- As of 26 October 2021, Antigua and Barbuda, Argentina, Aruba, Brazil, Canada, the Cayman Islands, Chile, Costa Rica, Curacao, French Guiana, Guadeloupe, Guatemala, Martinique, Mexico, Panama, Puerto Rico, Sint Maarten, Suriname, the United States of America, the United States Virgin Islands, and Uruguay have detected all four variants of concern (VOC).
- As of 28 October 2021, there have been a total of 325,344 SARS-CoV-2 infections among pregnant women, including 3,237 deaths (1.0% case-fatality rate), reported in 33 countries/territories in the Region.
- Among indigenous populations in 18 countries of the Americas, 665,006 cumulative cases were reported, including 16,430 deaths.
- A total of 27 countries and territories have reported 8,220 cumulative confirmed cases of multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19, including 160 deaths.
- Regarding health workers, 41 countries and territories have reported 2,176,474 cumulative cases, including 11,840 deaths.

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Context

On 31 December 2019, the People's Republic of China notified a cluster of pneumonia cases with unknown etiology, later identified on 9 January 2020 as a novel coronavirus by the Chinese Center for Disease Control and Prevention. On 30 January 2020, the World Health Organization (WHO) declared the outbreak a Public Health Emergency of International Concern (PHEIC). On 11 February 2020, WHO named the disease "coronavirus disease 2019 (COVID-19)," and the International Committee on Taxonomy of Viruses (ICTV) named the virus "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)". On 11 March 2020, COVID-19 was declared a pandemic by the WHO Director-General.¹ On 9 July 2020, the WHO Director-General announced the launch of the Independent Panel for Pandemic Preparedness and Response (IPPR), which will independently and comprehensively assess the lessons learned from the international health response to COVID-19.²

The ninth meeting of the Emergency Committee convened by the WHO Director-General under the International Health Regulations (2005) (IHR) regarding the coronavirus disease (COVID-19) took place on Friday, 22 October 2021. The Director-General determined that the COVID-19 pandemic continues to constitute a PHEIC and accepted the advice of the Committee to WHO and issued the Committee's advice to States Parties as Temporary Recommendations under the IHR, available at: <https://bit.ly/3bfbJ8P>.

Comparison periods

The most recent PAHO/WHO Epidemiological Update on COVID-19, published on 27 September 2021³, included data from approximately Between EW 34 (22-28 August 2021) and EW 37 (12-18 September 2021); thus, it covered the period from 22 August to 18 September 2021. The current report will include data from EW 38 (19-25 September 2021) to EW 42 (17-23 October 2021); thus, it covers the period from 19 September to 23 October 2021 (approximately one month of data), unless otherwise stated. The following tables and figures may include retrospective adjustments and relative increases may be a result of delayed notification.

Global Situation Summary

Since the first confirmed cases of COVID-19 until the end of EW 42, a cumulative total of 243,327,429 cases of COVID-19 have been reported globally, including 4,943,742 deaths; since the most recent PAHO/WHO Epidemiological Update on COVID-19 published on 27 September 2021.³ were reported a total of 15,256,257 additional confirmed cases and 251,667 additional deaths.

When comparing trends between the time periods covered in the 27 September 2021 PAHO/WHO Epidemiological Update on COVID-19 and the current report (EW 34-37 vs. EW 38-42), a decline in the number of new global cases (7.7% decrease) and deaths (3.8% decrease) has been observed.

¹ WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020. Available at: <https://bit.ly/3cRssQZ>

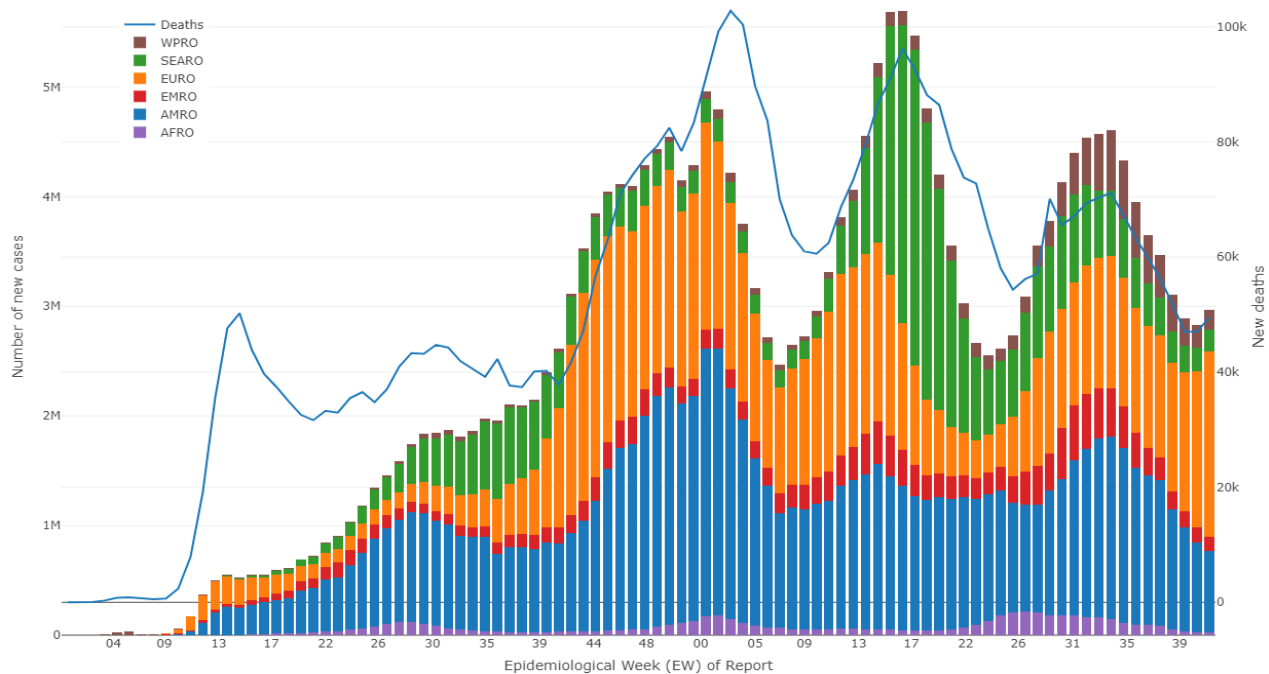
² Independent evaluation of global COVID-19 response announced. Available at: <https://bit.ly/31hLJWp>

³ Pan American Health Organization / World Health Organization. Epidemiological Update: Coronavirus disease (COVID-19). 27 September 2021, Washington, D.C.: PAHO/WHO; 2021

When looking at specific WHO Regions, declines in the number of new COVID-19 cases reported have been noted in AFRO (50%), EMRO (43.6%), SEARO (35.1%) and WPRO (33.5%). A decline has been observed in AMRO but to a lesser extent (18%). On the other hand, EURO has presented an increase (44.4%) in newly reported cases. Regarding deaths, a downward trend has been observed across most of the WHO Regions (AFRO, EMRO, SEARO, and WPRO). Following a similar pattern as the increase in newly reported cases, EURO has presented with an increase in the number of deaths by 55%. Additionally, in AMRO, deaths slightly increased (1.9%) during the same comparison period (**Figure 1**).

When analyzing the data by EW, the global downward trend in cases and deaths can be noted between EW 35 until EW 41. In EW 42, an increase in both cases (4.8%) and deaths (5.3%) compared to the previous week has been observed, driven by EURO.

Figure 1. Distribution of global COVID-19 confirmed cases and deaths, by epidemiological week (EW) of report and WHO Region, as of EW 42 of 2021.



Note:

AFRO: WHO Regional Office for Africa; AMRO: WHO Regional Office for the Americas; EMRO: WHO Regional Office for the Eastern Mediterranean; EURO: WHO Regional Office for Europe; SEARO: WHO Regional Office for South-East Asia; WPRO: WHO Regional Office for the Western Pacific

Source: WHO Coronavirus (COVID-19) data reproduced by PAHO/WHO. Available at: <https://covid19.who.int/info/>. Accessed on 27 October 2021.

Situation Summary in the Region of the Americas

Since January 2020 – when the first COVID-19 cases were detected in the Region – and until EW 42 of 2021, a cumulative total of 92,938,190 confirmed cases of COVID-19, including 2,279,126 deaths, have been reported from all 56 countries and territories in the Region of the Americas, accounting for 38.2% of the globally reported cases, and 46.1% of the globally reported deaths.

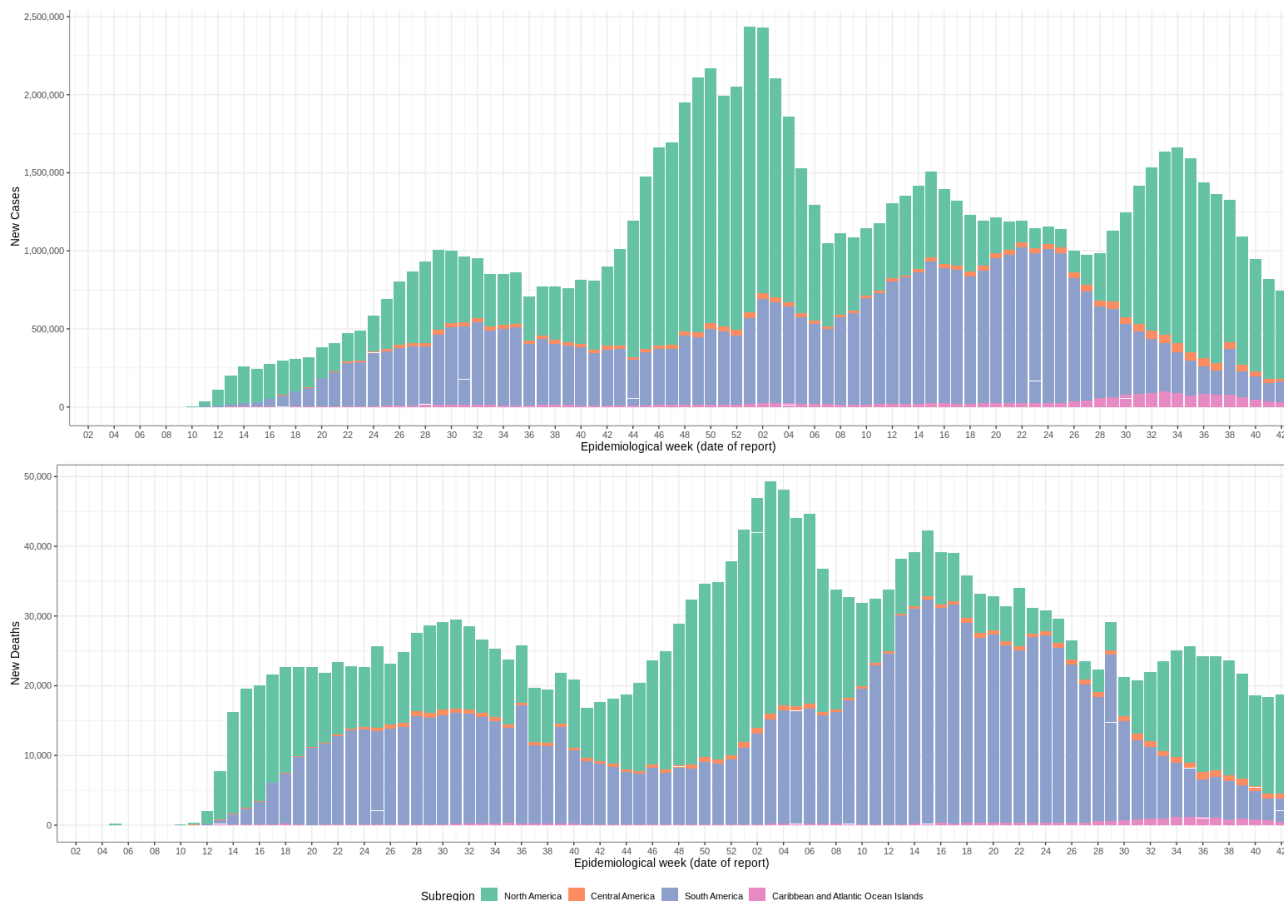
Since the end of EW 37 covered in the previous PAHO/WHO Epidemiological Update on COVID-19, published on 27 September 2021³ and as of the end of EW 42, 4,932,478 additional confirmed cases of COVID-19, including 101,057 additional deaths, have been reported in the Region of the Americas.

In comparison with the previous 4-week period (EW 34-EW 37), the number of reported cases decreased across all subregions except for South America, where a 5.7% increase was observed. Comparing the same periods, the number of reported deaths increased in the North America (11.7%) and Central America (7.9%) subregions, while they decreased in the South America and the Caribbean and Atlantic Ocean Islands subregions.

North America remained the major contributor to the number of new cases in this period (3,663,638, or 74.3% of the cases reported in the Region), followed by South America (858,093 or 17.4%), the Caribbean and Atlantic Ocean Islands (250,133, or 5.1%), and Central America (160,614, or 3.3%) (**Figure 2a**).

The North America subregion also accounted for the highest proportions of reported deaths (71.8%) during EW 38 – EW 42, with a total of 72,545 deaths reported, which represents an increase of 11.7% compared to the previous period (**Figure 2b**).

Figure 2a-b. Distribution of confirmed COVID-19 cases and deaths, by subregion and epidemiological week (EW) of report. Region of the Americas. As of EW 42 of 2021.



Source: Information shared by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies or similar and reproduced by PAHO/WHO.

Spotlight on the South America subregion

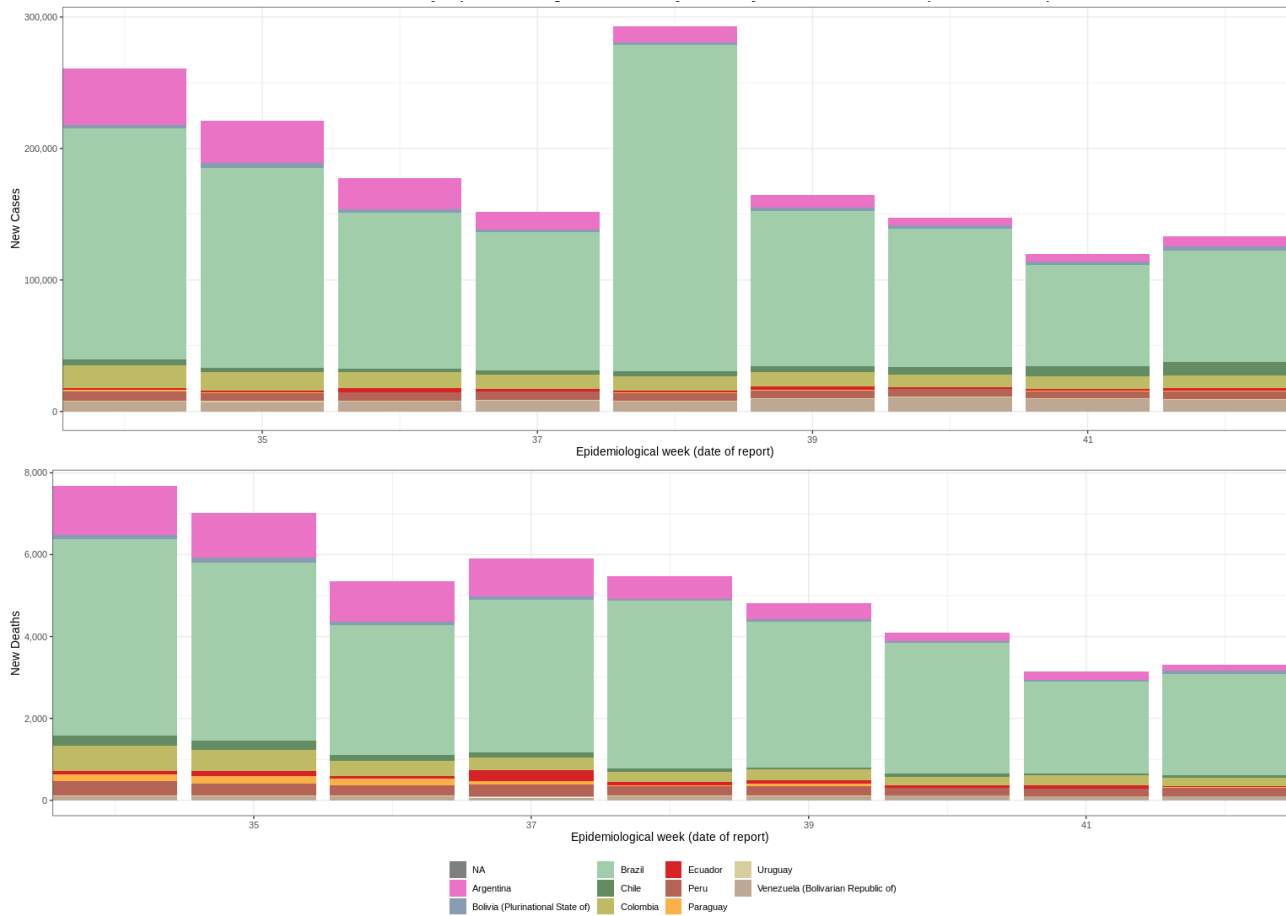
The following is a brief description of the COVID-19 trends in cases and deaths observed in the **South America** subregion.

In South America, increasing trends in the number of reported cases (ranging from 12.3% to 138.6%) were observed in most countries of the subregion during EW 38 – EW 42 in comparison to EW 34 – EW 37, with the highest percent increase noted in Chile (138.6%), followed by Venezuela (51.3%). Related to deaths, while nearly all countries of this subregion reported a decrease in the number of reported deaths, Venezuela experienced an increase of 27.5% compared to the previous period.

During this period, Brazil (632,197 cases or 73.7% of cases reported in the Region), followed by Colombia (50,425 cases or 5.9%), and Venezuela (45,210 cases or 5.3%) were the main contributors to the case toll in this subregion (**Figure 3a**). Brazil (15,566 deaths or 74.6% of deaths reported in the Region) was also the major contributor to the death toll in this subregion during this period, followed by Argentina (1,533 deaths or 7.4%), and Colombia (1,168 deaths or 5.6%) (**Figure 3b**).

While an overall declining trend was observed in this subregion, except for the data adjustment noted in EW 38, a slight increase in cases can be observed in EW 42 compared to EW 41.

Figure 3a-b. Distribution of confirmed COVID-19 cases and deaths by country and epidemiological week (EW) of report. The South America subregion. EW 34 - EW 42 of 2021.



Note: During this period, Brazil included a data adjustment in EW 38. Data must be interpreted with caution as countries regularly include adjustments.

Source: Information shared by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies or similar and reproduced by PAHO/WHO.

Epidemiological Highlights

I. SARS-CoV-2 Variants

The appearance of mutations is a natural and expected event within the evolutionary process of viruses. Since the initial genomic characterization of SARS-CoV-2, this virus has been divided into different genetic groups or clades. In fact, some specific mutations define the viral genetic groups (also called lineages) that are currently circulating globally. Due to various microevolution processes and selection pressures, some additional mutations may appear, generating differences within each genetic group (called variants). It is important to mention that the names of the clade, lineage, variant, etc., are arbitrary and do not correspond to an official taxonomic hierarchy.

Since the initial identification of SARS-CoV-2 until 28 October 2021, more than 4,691,504 genomic sequences have been shared globally through publicly accessible databases.

As of 28 October 2021, 54 countries and territories in the Americas have published a total of 1,750,404 SARS-CoV-2 sequences on the GISAID platform, collected between February 2020 and October 2021. Countries and territories that have reported a variant of concern (VOC) and contributed genome data to GISAID are depicted in **Tables 3a-d**. To note, the Falkland Islands (Malvinas) has reported VOCs but not contributed genome data to GISAID and is included in Table 3d, while Sint Eustatius has contributed to GISAID but has not detected a VOC in the territory and therefore does not appear in Table 3d.

On 25 February 2021, WHO provided proposed operational definitions for SARS-CoV-2 variants of interest (VOI) and VOC and the associated actions that WHO will take to support Member States and their national public health institutes and reference laboratories, along with recommended actions that should be taken by Member States. The document includes general and non-exhaustive guidance on the prioritization of variants of greatest public health relevance in the broader context of SARS-CoV-2 transmission, and public health response mechanisms and established social distance measures. These definitions are periodically reviewed and updated, as necessary. Information on variants available at: <https://bit.ly/3gmGoEc>

On 31 May 2021, WHO announced assigning simple labels for SARS-CoV-2 VOI and VOC that are easy to say and remember; the labels do not replace existing scientific names, but rather they are intended to simplify public communications.⁴ The labels are available at: <https://bit.ly/39Ja6Q0>

The list of SARS-CoV-2 variants, according to the WHO classification as of 22 October 2021,⁵ is available in **Table 1**.

⁴ WHO. WHO announces simple, easy-to-say labels for SARS-CoV-2 Variants of Interest and Concern. 31 May 2021. Available at: <https://bit.ly/3xaARqs>

⁵ WHO. Tracking SARS-CoV-2 variants. Available at: <https://bit.ly/36FXgQY>

Table 1. SARS-CoV-2 variants of concern (VOC) and variants of interest (VOI), according to WHO classifications as of 22 October 2021.

SARS-CoV-2 Variants WHO classification	WHO Label	Pango lineage*	First detected in
Variants of concern (VOC)	Alpha	B.1.1.7 †	United Kingdom
	Beta	B.1.351	South Africa
	Gamma	P.1	Brazil
	Delta	B.1.617.2 §	India
Variants of interest (VOI)	Lambda	C.37	Peru
	Mu	B.1.621	Colombia

Notes:

*Includes all descendent lineages. The full list of Pango lineages can be found at <https://bit.ly/3IAhser>; for FAQ, visit: <https://bit.ly/2VQQYMJ>

† includes all Q.* lineages (in the Pango nomenclature system, Q is an alias for B.1.1.7)

§ includes all AY.* lineages (in the Pango nomenclature system, AY is an alias for B.1.617.2); for more information on AY.* lineages, please visit: <https://bit.ly/3IFf99V>

Source: WHO. Tracking SARS-CoV-2 variants.⁵ Accessed on 27 October 2021.

Globally, an increase in the number of countries and territories reporting VOC and VOI continues to be observed (**Table 2**).

Table 2. Summary of the countries/territories reporting cases of SARS-CoV-2 variants of concern (VOC), as of 26 October 2021.

	WHO Label			
	Alpha	Beta	Gamma	Delta
Number of countries/territories reporting cases globally	193	142	96	185
Number of countries/territories reporting cases in the Americas	49	25	41	52

Note: Some countries have reported more than one VOC.

Source: WHO. COVID-19 Weekly Epidemiological Update. Published on 26 October 2021.⁶

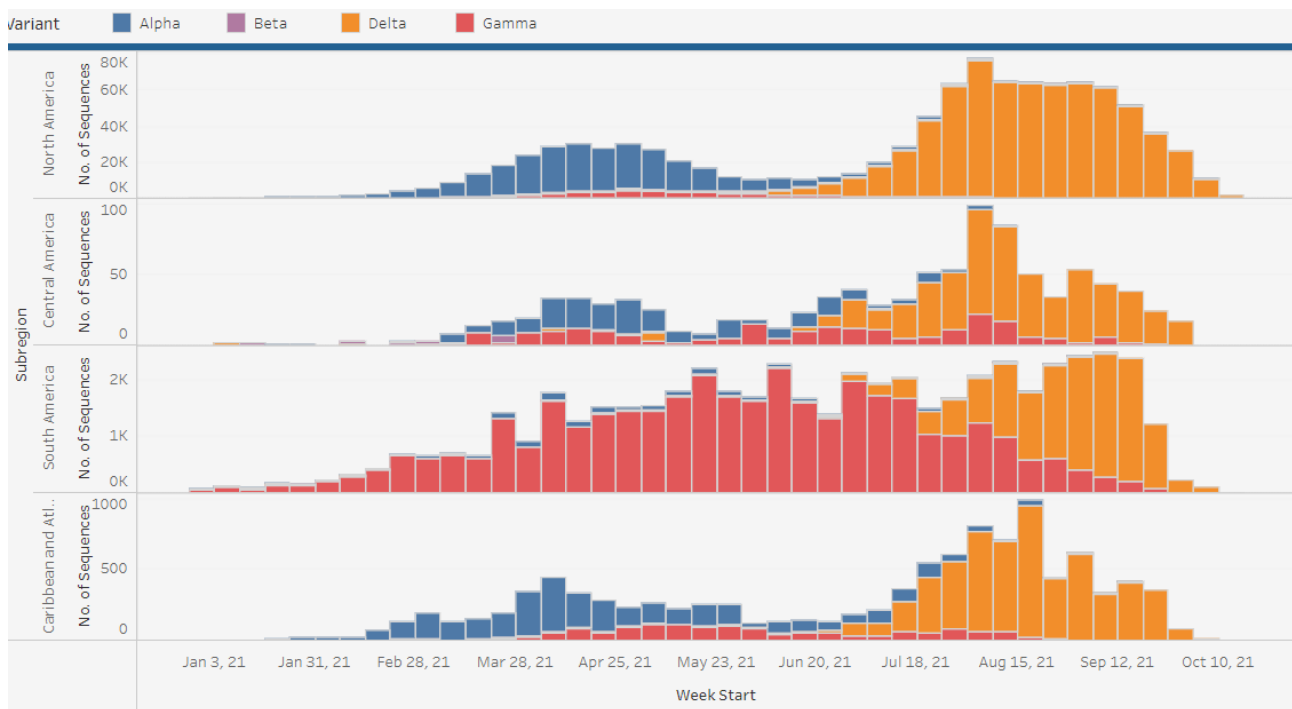
Information shared by the International Health Regulations (IHR) National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies, or similar.

Since April 2021, an exponential increase in VOC Delta samples globally has been observed. In July 2021, a global predominance of VOC Delta was observed in almost 90% of the samples worldwide, including Member States in the Americas. On 8 August 2021, PAHO/WHO published an Epidemiological Update related to the increase of VOC Delta and its potential impact in the Region of the Americas.⁶

When analyzing SARS-CoV-2 sequences submitted to publicly available databases in the last 60 days, it can be observed that VOC Delta continues to predominate at the global level while the prevalence of other VOC declines. This trend is also observed in countries of the Region of the Americas; however, the spread of VOC Delta has been more gradual than in other Regions. This is particularly true in the South America subregion, where the proportion of VOC Gamma continues to account for 0.101 to 0.500 of sequences uploaded to GISAID for Argentina, Chile, and Peru.⁶

To note, the prevalence observed globally should be interpreted with caution due to differences and limitations related to surveillance systems or surveillance mechanisms, as well as the capacity of the countries and territories to sequence samples, and differences in the selection of samples to be sequenced. The distribution of VOC by subregion are presented in **Figure 4**.

Figure 4. Distribution of SARS-CoV-2 variants of concern (VOC) by subregion submitted to publicly available databases. Region of the Americas. January to October 2021.



As of 26 October 2021, the detection of all four VOC has been reported in Antigua and Barbuda, Argentina, Aruba, Brazil, Canada, the Cayman Islands, Chile, Costa Rica, Curacao, French Guiana, Guadeloupe, Guatemala, Martinique, Mexico, Panama, Puerto Rico, Sint Maarten, Suriname, the United States of America, the United States Virgin Islands, and Uruguay.

⁶ PAHO/WHO. Epidemiological Update: Increase of the Delta variant and its potential impact in the Region of the Americas. 8 August 2021, Washington, D.C. PAHO/WHO. 2021. Available at: <https://bit.ly/3v2Rm7K>

Table 3a. Countries reporting SARS-CoV-2 variants of concern (VOC) in the North America subregion, as of 26 October 2021.

Country	Alpha	Beta	Gamma	Delta
Canada	√	√	√	√
Mexico	√	√	√	√
United States of America	√	√	√	√

Table 3b. Countries reporting SARS-CoV-2 variants of concern (VOC) in the Central America subregion, as of 26 October 2021.

Country	Alpha	Beta	Gamma	Delta
Belize	√		√*	√*
Costa Rica	√	√	√	√
El Salvador	√		√*	√
Guatemala	√	√	√	√
Honduras	√		√	√
Panama	√	√	√	√*

Table 3c. Countries reporting SARS-CoV-2 variants of concern (VOC) in the South America subregion, as of 26 October 2021.

Country	Alpha	Beta	Gamma	Delta
Argentina	√	√	√	√
Bolivia	√		√	
Brazil	√	√	√	√
Chile	√	√	√	√
Colombia	√		√	√
Ecuador	√		√	√
Paraguay	√		√	√
Peru	√		√	√
Uruguay	√	√*	√	√*
Venezuela	√		√	√

Table 3d. Countries and territories reporting SARS-CoV-2 variants of concern (VOC) in the Caribbean and Atlantic Ocean Islands subregion, as of 26 October 2021.

Country/Territory	Alpha	Beta	Gamma	Delta
Anguilla	√			√
Antigua and Barbuda	√	√	√*	√*
Aruba	√	√	√	√
Bahamas	√		√	√
Barbados	√		√	√
Bermuda	√	√		√
Bonaire	√		√	√
British Virgin Islands	√		√	√
Cayman Islands	√	√	√	√
Cuba	√	√		√*
Curaçao	√	√*	√	√
Dominica	√			√*
Dominican Republic	√		√	√
Falkland Islands (Malvinas)	√*	√*		
French Guiana	√	√	√	√
Grenada	√			√
Guadeloupe	√	√	√	√
Guyana			√	√
Haiti	√		√	√
Jamaica	√			√
Martinique	√	√	√	√
Montserrat	√		√	√
Puerto Rico	√	√	√	√
Saba				√
Saint Barthélemy	√			√
Saint Kitts and Nevis				√*
Saint Lucia	√			√
Saint Martin	√	√		√*
Saint Pierre and Miquelon				√*
Saint Vincent and the Grenadines			√*	√
Sint Maarten	√	√	√	√
Suriname	√	√	√	√
Trinidad and Tobago	√		√	√
Turks and Caicos	√		√	√
United States Virgin Islands	√	√*	√	√

Note: Data are provisional and subject to change as countries and territories make adjustments and retrospective analysis.

* Sequence is not available yet in an international repository.

Source: Information shared by the IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies or similar, and reproduced by PAHO/WHO.

II. COVID-19 detailed surveillance data

Characterization of cases including age, sex, clinical course (hospitalization or admittance to the intensive care unit), and outcome (recovered case or death) is essential for understanding the evolution of the pandemic. Additionally, while several countries have begun including the vaccination status of cases, this variable is not currently available for case data in many countries.

Member States provide detailed surveillance data to WHO; this data is available in the WHO COVID-19 Dashboard. In the Region of the Americas, the proportion of countries reporting age, clinical course, and outcome varies by subregion, as depicted in **Table 4**. All countries in North America continue reporting detailed information for the above-mentioned variables. Overall, the lowest proportion of countries and territories reporting detailed surveillance data is observed in the Caribbean and Atlantic Ocean Islands subregion.

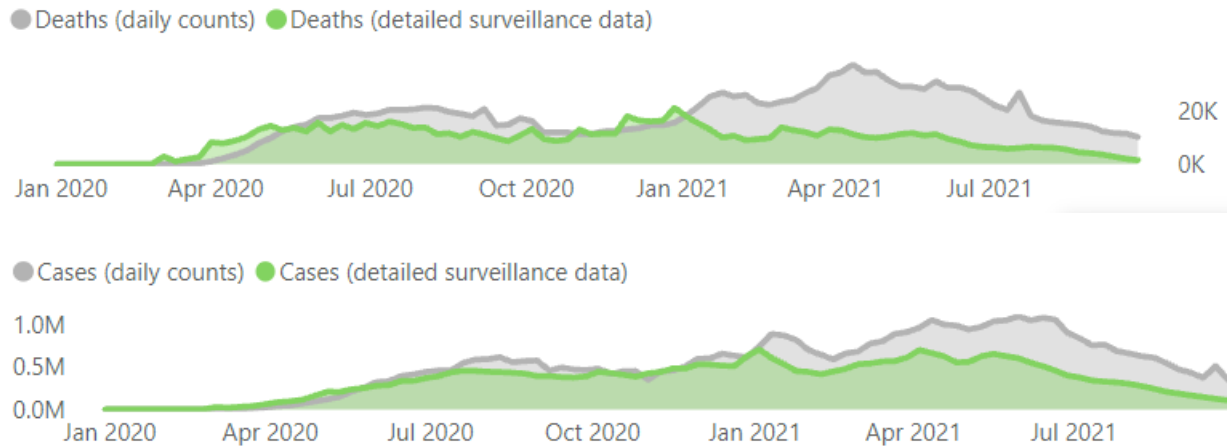
Table 4. Proportion of countries reporting age, clinical course, and outcome, by subregion. Region of the Americas, as of 20 October 2021.

Subregion	% of countries and territories reporting age	% of countries and territories reporting clinical course	% of countries and territories reporting outcome
Caribbean and Atlantic Ocean Islands	61.8%	55.9%	50.0%
Central America	85.7%	85.7%	71.4%
North America	100.0%	100.0%	100.0%
South America	80.0%	70.0%	60.0%
All subregions	70.4%	64.8%	57.4%

Source: Information shared by IHR National Focal Points (NFPs) and reproduced by PAHO/WHO.

Figure 5 shows the availability of age information among COVID-19 cases and deaths received through detailed surveillance data as compared to daily counts. It is worth noting that data cleaning is continuous and important delays can be observed when comparing to daily counts.

Figure 5. Availability of age information among COVID-19 cases and deaths received through detailed surveillance data as compared to daily counts. As of September 2021.



Source: WHO Coronavirus (COVID-19) data. Available at: <https://covid19.who.int/info/>

II. Vaccination and hospitalizations

Some of the articles published^{7,8,9,10}, or pre-published, on the impact of COVID-19 vaccination campaigns provide hope in achieving a decrease in mortality rates and hospitalizations in intensive care units (ICU), particularly among older adults. However, it is important to consider that COVID-19 vaccination campaigns are not sufficient in and of themselves to prevent and control the transmission of SARS-CoV-2; therefore, public health and social distancing measures should be maintained in accordance with the epidemiological situation of each country and territory.

The following maps in **Figure 6** show the percentage of population who have completed the COVID-19 vaccine schedule at the end of EW 42 (left) versus the average number of current COVID-19 ICU occupancy per 1,000 new COVID-19 cases between EW 41 and EW 42 of 2021 (right). To note, the average number of COVID-19 ICU hospitalizations is calculated using the total number of ICU hospitalizations reported per day; therefore, the duration of stay will affect the presented rates.

In **North America**, the United States and Canada reported more than 50% vaccine coverage, accompanied by relatively low ICU occupancy rates per 1,000 new cases.

⁷ Cook TM, Roberts JV. Impact of vaccination by priority group on UK deaths, hospital admissions and intensive care admissions from COVID-19. Available at: <https://doi.org/10.1111/anae.15442>

⁸ Leshem E, Wilder-Smith A. COVID-19 vaccine impact in Israel and a way out of the pandemic. *The Lancet* 2021 May 5 doi: 10.1016/S0140-6736(21)01018-7. Available at: <https://bit.ly/3hk18xC>

⁹ Haas E, Angulo F, et al. Impact and effectiveness of mRNA BNT162b2 vaccine against SARS-CoV-2 infections and COVID-19 cases, hospitalizations, and deaths following a nationwide vaccination campaign in Israel: an observational study using national surveillance data. *The Lancet* 2021, ISSN 0140-6736, Available at: [https://doi.org/10.1016/S0140-6736\(21\)00947-8](https://doi.org/10.1016/S0140-6736(21)00947-8)

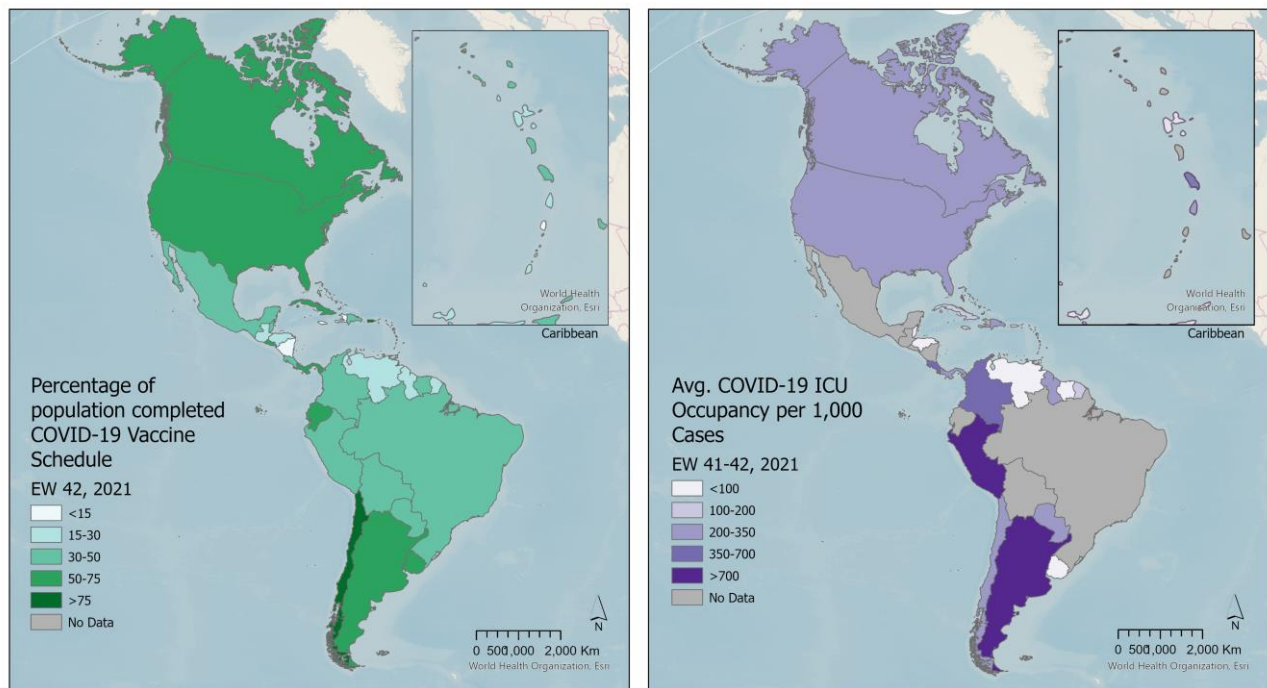
¹⁰ Moghadas, SM, Vilches, TN, Zhang, et al. The impact of vaccination on COVID-19 outbreaks in the United States. *Clin Infect Dis* 2021; Available at: <http://doi.org/10.1093/cid/ciab079>

In **Central America**, Costa Rica has relatively low vaccine coverage along with a moderately high ICU occupancy rate (>200 per 1,000 new cases). Panama reported >50% vaccine coverage, while experiencing a moderately low ICU occupancy rate in the last 2 weeks.

In **South America**, Chile has over 75% vaccine coverage with a low ICU occupancy rate. Argentina has >50% vaccine coverage; however, the ICU occupancy appears high (>700 per 1,000 new cases). Colombia and Peru, with a vaccination coverage between 30% and 50%, each have an ICU occupancy rate of 350 per 1,000 new cases.

In the **Caribbean and Atlantic Ocean Islands**, Cuba and Puerto Rico have >50% vaccine coverage accompanied by a relatively low ICU occupancy rate. Bahamas and Martinique have <50% vaccine coverage with a relatively high current ICU occupancy (>350 per 1,000 new cases).

Figure 6. Percentage of population who have completed the COVID-19 vaccine schedule at the end of epidemiological week (EW) 42 of 2021 (left) versus the average COVID-19 intensive care unit (ICU) occupancy per 1,000 new COVID-19 cases between EW 41 and EW 42 of 2021 (right). Region of the Americas.



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Source: Information shared by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, Health Agencies or similar and reproduced by PAHO/WHO.

IV. COVID-19 during pregnancy

Although researchers continue to advance the knowledge base related to COVID-19 among pregnant women, helping to close existing knowledge gaps related to the impact of SARS-CoV-2 infection on the outcome of pregnancy, it is necessary to continue collecting information to contribute to that knowledge base.

COVID-19 vaccination campaigns, together with social distancing measures, hand hygiene and the proper use of face masks, targeted to this population group are expected to impact the severity and mortality observed thus far.

Since the first reported cases of COVID-19 in the Americas and until 28 October 2021, there have been a total of 325,344 SARS-CoV-2 infections among pregnant women, including 3,237 deaths (1.0% case-fatality rate), reported in 33 countries/territories for which information was available; this report includes data from one additional territory (Turks and Caicos Islands) compared to the previous report.

Compared to the data presented in the last PAHO/WHO Epidemiological Update on COVID-19, published on 27 September 2021,³ this represents 21,872 additional cases and 214 additional deaths. During the same period, the highest relative increases in cumulative confirmed cases occurred in Saint Lucia (37%, 17 additional cases) and Haiti (25%, 27 additional cases). Among deaths, the highest relative increases were observed in Suriname (38%, 8 additional deaths) and Guatemala (33%, 5 additional deaths) (**Table 5**).

Table 5. SARS-CoV-2 infections and deaths among pregnant women, by country/territory. Region of the Americas. January 2020 to 28 October 2021*.

Country	Number of pregnant women positive for SARS-CoV-2	Number of deaths among pregnant women positive for SARS-CoV-2	Case-fatality rate (%)
Anguilla	6	0	N/A
Antigua and Barbuda**	4	0	0.00
Argentina	22,328	210	0.94
Bahamas**	101	1	0.99
Belize**	315	2	0.63
Bermuda	11	0	0.00
Bolivia**	3,405	51	1.50
Brazil †	15,086	1,283	8.50
British Virgin Islands	3	0	N/A
Canada	8,552	3	0.04
Cayman Islands	9	0	0.00
Chile	16,093	16	0.10
Colombia	17,812	190	1.07
Costa Rica	1,281	10	0.78
Cuba	5,827	95	1.63
Dominican Republic**	1,935	81	4.19
Ecuador	1,750	55	3.14
El Salvador**	564	15	2.66
Guatemala	1,958	15	0.77
Guyana**	13	N/A	N/A
Haiti	106	4	3.77
Honduras**	818	56	6.85
Mexico&	29,813	610	2.05
Panama&&	2,406	14	0.58
Paraguay&	2,154	87	4.04
Peru&	55,160	185	0.34
Saint Kitts and Nevis**	15	0	0.00
Saint Lucia	46	0	0.00
Suriname	572	21	3.67
Turks and Caicos Islands	28	0	0.00
United States of America	134,687	205	0.15
Uruguay	1,709	12	0.70
Venezuela	777	16	2.06
Total	325,344	3,237	1.00

Note:

N/A: Data not available.

& Corresponds to pregnant and postpartum women

† The information presented for Brazil corresponds data extracted from the Influenza Epidemiological Surveillance Information System (SIVEP-Gripe).

* 28 October 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

** No update since the 27 September 2021 PAHO/WHO Epidemiological Update on COVID-19³

Source: Latin American Center for Perinatology/Women's Health and Reproductive Health (CLAP/SMR) and information shared with PAHO/WHO by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, health agencies, or similar and reproduced by PAHO/WHO.

According to data obtained from 24 countries in 2021 compared to the data reported in 2020, there has been an increase in both the number of cases and deaths among pregnant women positive for SARS-CoV-2 infection (**Table 6**). While most countries have reported a higher maternal mortality ratio (MMR) in the current year, this increase has been particularly high in some countries such as Suriname, where an 854% increase in the MMR is observed when comparing data from 2020 to 2021. Several factors may explain the variations shown below, including differences in surveillance systems, surveillance strategies as the pandemic evolves, immunization strategies, and vaccine availability for pregnant women in different countries.

Table 6. Select COVID-19 indicators related to pregnancy in countries of the Americas, 2020 and 2021 (January to October 2021).

Country	Year 2020			January - October 2021		
	Number of pregnant women positive for SARS-CoV-2	Number of deaths among pregnant women positive for SARS-CoV-2	MMR*	Number of pregnant women positive for SARS-CoV-2	Number of deaths among pregnant women positive for SARS-CoV-2	MMR*
Argentina ^{&}	8,996	41	5.5	13,332	169	22.5
Belize	181	2	24.8	131	0	0.0
Bolivia	963	31	12.5	2,442	20	8.1
Brazil	5,468	256	9.0	9,618	1,027	36.4
Canada	2,925	1	0.3	5,627	2	0.5
Chile	6,616	2	1.0	9,477	14	10.5
Colombia	7,979	56	7.7	9,833	134	24.4
Costa Rica	335	3	5.2	946	7	0.7
Cuba	180	0	0.0	5,647	95	87.3
Dominican Republic	707	36	17.6	1,228	45	42.1
Ecuador	1,526	28	8.3	224	27	8.0
El Salvador	272	10	9.0	292	5	4.5
Guatemala	652	8	1.9	1,306	7	1.6
Haiti	79	4	5.1	27	0	0.0
Honduras	508	15	7.2	310	41	19.6
Mexico ^{&}	10,568	205	9.4	19,245	405	26.3
Panama ^{&}	1,852	4	5.0	561	10	12.5
Paraguay ^{&}	599	1	0.7	1,555	86	60.1
Peru	40,818	81	14.3	14,342	104	18.3
Saint Lucia	5	0	0.0	24	0	0.0
Suriname ^{&}	184	2	18.9	388	19	180.3
United States of America	68,459	80	2.0	66,228	125	3.1
Uruguay	106	0	0.0	1,603	12	25.5
Venezuela	338	9	1.5	439	7	1.1

Note: [&] Corresponds to pregnant and postpartum women

* MMR Maternal mortality ratio, calculated using deaths among pregnant women (in some instances, including postpartum deaths) positive to SARS-CoV-2. Per 100,000 live new births.

Source: Latin American Center for Perinatology/Women's Health and Reproductive Health (CLAP/SMR) and information shared with PAHO/WHO by IHR National Focal Points (NFPs) or published on the websites of the Ministries of Health, health agencies, or similar and reproduced by PAHO/WHO.

V. COVID-19 among indigenous populations

Since January 2020 and until 28 October 2021, there have been 665,006 confirmed cases of COVID-19, including 16,430 deaths, reported among indigenous populations in 18 countries in the Region of the Americas for which information was available (**Table 7**). Compared to the data in the last PAHO/WHO Epidemiological Update on COVID-19, published on 27 September 2021,³ this represents 31,118 additional cases and 678 additional deaths. During the same period, the largest relative increases in cases were observed in Guatemala (23%, 8,487 additional cases) and in Canada (16%, 7,339 additional cases) while the largest relative increases in deaths were observed in Suriname (17%, 12 additional deaths) and Canada (13%, 61 additional deaths).

Table 7. Cumulative number of confirmed cases and deaths of COVID-19 among indigenous populations in the Region of the Americas. January 2020 to 28 October 2021*.

Country	Number of COVID-19 confirmed cases	Number of deaths
Argentina	3,162	115
Belize**	2,093	45
Bolivia**	30,603	575
Brazil	54,351	826
Canada	45,602	469
Chile	68,425	1,275
Colombia	70,902	2,069
Costa Rica	2,622	36
Ecuador	6,079	222
Guatemala	36,776	749
Guyana**	95	6
Mexico	33,646	4,155
Panama**	6,918	123
Paraguay	595	77
Peru	30,947	687
Suriname	2,908	72
United States of America †	267,593	4,860
Venezuela	1,689	69
Total	665,006	16,430

Note:

* 28 October 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

** No update since the 27 September 2021 PAHO/WHO Epidemiological Update on COVID-19.³

† No update was available for the number of deaths among Indigenous populations.

Source: Data provided by the International Health Regulations (IHR) National Focal Points (NFPs) or published by the Ministries of Health, Institutes of Health, indigenous organizations, or similar and reproduced by PAHO/WHO.

VI. COVID-19 among populations under 20 years of age

Since the beginning of the pandemic, it has been apparent that children and adolescents, compared to other age groups, have a lower risk of illness and death from COVID-19. Additionally, it has been recognized that children and adolescents are being particularly affected by the measures taken to control the transmission of the virus. These indirect effects include the negative consequences of school closures, restrictions on the movement of people which limit opportunities for play and relationships with family and friends, the loss of work and income that also affect the mental health of caregivers and consequently the relationships between children and their caregivers, and the disruption of health and social protection services, among others.¹¹ In order to support Member States and decision-makers, PAHO/WHO has issued Considerations for school-related public health measures for populations in vulnerable conditions in the context of COVID-19. The full report is available at: <https://bit.ly/3Evxv1B>.

The evidence available to date suggests that children and adolescents are less susceptible to SARS-CoV-2 infection and transmit the virus less frequently than adults. When they do acquire infection, they are generally asymptomatic and, when they do get sick, they usually have mild illness with symptoms like other common illnesses at these ages. Within the 0-19 age group, studies suggest that susceptibility and transmission are lower among children under 5 years of age than among older children and adolescents.^{12,13,14,15,16}

Although further evidence is required, some studies suggest that children, as in the case of adults, may present long lasting symptoms related to SARS-CoV-2 infection.^{17,18} Findings from a prospective cohort study involving children aged 5 to 17-years-old in the United Kingdom showed that while disease is usually short and with low burden in children, a small proportion (<2%) presented with long-term illness after infection by SARS-CoV-2.¹⁹

The latest WHO Scientific Brief on COVID-19 in children and adolescents summarizes current knowledge about SARS-CoV-2 acquisition and transmission in this population. The full report is available at: <https://bit.ly/3pOg4Zm>.

¹¹ UN Sustainable Development Group. Policy Brief: The Impact of COVID-19 on children. April 2020. Available at: <https://bit.ly/38r1JbH>

¹² Gaythorpe, K. A., Bhatia, S., Mangal, T., et al. Children's role in the COVID-19 pandemic: a systematic review of early surveillance data on susceptibility, severity, and transmissibility. Imperial College London. 3–26. DOI: <https://doi.org/10.25561/84220>

¹³ Viner, R. M., Mytton, O. T., Bonell, C., et al. Susceptibility to SARS-CoV-2 Infection among Children and Adolescents Compared with Adults: A Systematic Review and Meta-Analysis. *JAMA Pediatrics*, 175(2), 143–156. DOI: <https://doi.org/10.1001/jamapediatrics.2020.4573>

¹⁴ Viner, R. M., Russell, S., Saulle, R., et al. Impacts of school closures on physical and mental health of children and young people: a systematic review. *MedRxiv*, 2021.02.10.21251526. <https://doi.org/10.1101/2021.02.10.21251526>

¹⁵ Davies, N.G., Klepac, P., Liu, Y. et al. Age-dependent effects in the transmission and control of COVID-19 epidemics. *Nat Med* 26, 1205–1211 (2020). DOI: <https://doi.org/10.1038/s41591-020-0962-9>

¹⁶ Leidman E, Duca LM, Omura JD, Proia K, Stephens JW, Sauber-Schatz EK. COVID-19 Trends Among Persons Aged 0–24 Years — United States, March 1–December 12, 2020. *MMWR Morb Mortal Wkly Rep* 2021; 70:88–94. DOI: <http://dx.doi.org/10.15585/mmwr.mm7003e1>

¹⁷ Buonsenso D, Munblit D, De Rose C, et al. Preliminary evidence on long COVID in children. *Acta Paediatr*. 2021;110(7):2208-2211. DOI: <https://doi.org/10.1111/apa.15870>

¹⁸ Brackel, L.H., Lap, C.R., Buddingh, E.P. et al. Pediatric long-COVID: An overlooked phenomenon? *Pediatric Pulmonology*, 2021 (56); 2495-2502. DOI: <https://doi.org/10.1111/apa.15870>

¹⁹ Molteni, E., Sudre, C.H., Canas, L.S., et al. Illness duration and symptom profile in symptomatic UK school-aged children tested for SARS-CoV-2. *The Lancet Child & Adolescent Health*, 2021. DOI: [https://doi.org/10.1016/S2352-4642\(21\)00198-X](https://doi.org/10.1016/S2352-4642(21)00198-X).

Multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19

Globally, various reports and scientific publications, have described groups of children and adolescents requiring admission to intensive care units (ICU) due to a multisystem inflammatory condition with some features similar to those of Kawasaki disease and toxic shock syndrome. Based on the available evidence, WHO has provided the case definition of this syndrome, called multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19, available at: <https://bit.ly/2RBZzgr>.

Although MIS-C is considered a rare event, these cases present important challenges for health systems, and can lead to severe clinical presentations and even death.

In the Region of the Americas, PAHO/WHO began active surveillance of MIS-C cases in June 2020, inviting Member States to share a minimum set of epidemiological variables allowing for the characterization of MIS-C in the Region.

Between mid-May 2020 and 29 October 2021, a cumulative total of 8,220 confirmed cases of MIS-C temporally related to COVID-19, including 160 deaths (case-fatality rate 1.95%), have been reported in 27 countries/territories of the Region of the Americas (**Table 8**); three additional countries/territories, **Martinique**, **Saint Lucia**, and **Uruguay**, recently reported cases for the first time. During this same period, 21 countries and territories have officially reported to PAHO/WHO that they have not detected cases of MIS-C.

Since the last PAHO/WHO Epidemiological Update on COVID-19, published on 27 September 2021 and until 29 October 2021, there were 673 additional confirmed cases reported and 7 additional deaths.

As the numbers of cases of MIS-C increase, it is important that each country/territory characterizes the cases²⁰ to better understand the clinical presentation and outcomes, severity, treatment.

²⁰ Case notification form available at: <https://bit.ly/3jlbGvw>.

Table 8. Distribution of cumulative confirmed cases and deaths of multisystem inflammatory syndrome in children and adolescents (MIS-C) temporally related to COVID-19 in the Region of the Americas, by country/territory. May 2020 to 29 October 2021*.

Country/Territory	Number of Confirmed Cases	Number of Confirmed Deaths
Argentina	215	1
Barbados	2	1
Bolivia	1	1
Brazil	1,347	82
Canada	145	0
Chile	395	5
Colombia	17	6
Costa Rica	50	1
Cuba	3	0
Dominican Republic	144	6
Ecuador	28	0
El Salvador	30	0
French Guiana	3	0
Guadeloupe	15	0
Guatemala	2	0
Honduras	3	0
Martinique	13	0
Panama	81	2
Paraguay	145	9
Peru	21	0
Puerto Rico	*	*
Saint Lucia	1	0
Saint Martin	2	0
Trinidad and Tobago	29	0
United States	5,311	46
Uruguay	22	0
Venezuela	195	0
Total	8,220	160

Notes: *29 October 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

According to the United States Centers for Disease Control and Prevention (US CDC) website, the data for the United States includes 52 US jurisdictions (including 49 states, New York City, Puerto Rico, and Washington, DC). Available at: <https://bit.ly/2SrKBOj>

Sources: Data provided by the International Health Regulations (IHR) National Focal Points (NFPs) or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

The following is a brief description of the epidemiological situation of MIS-C in the Americas.

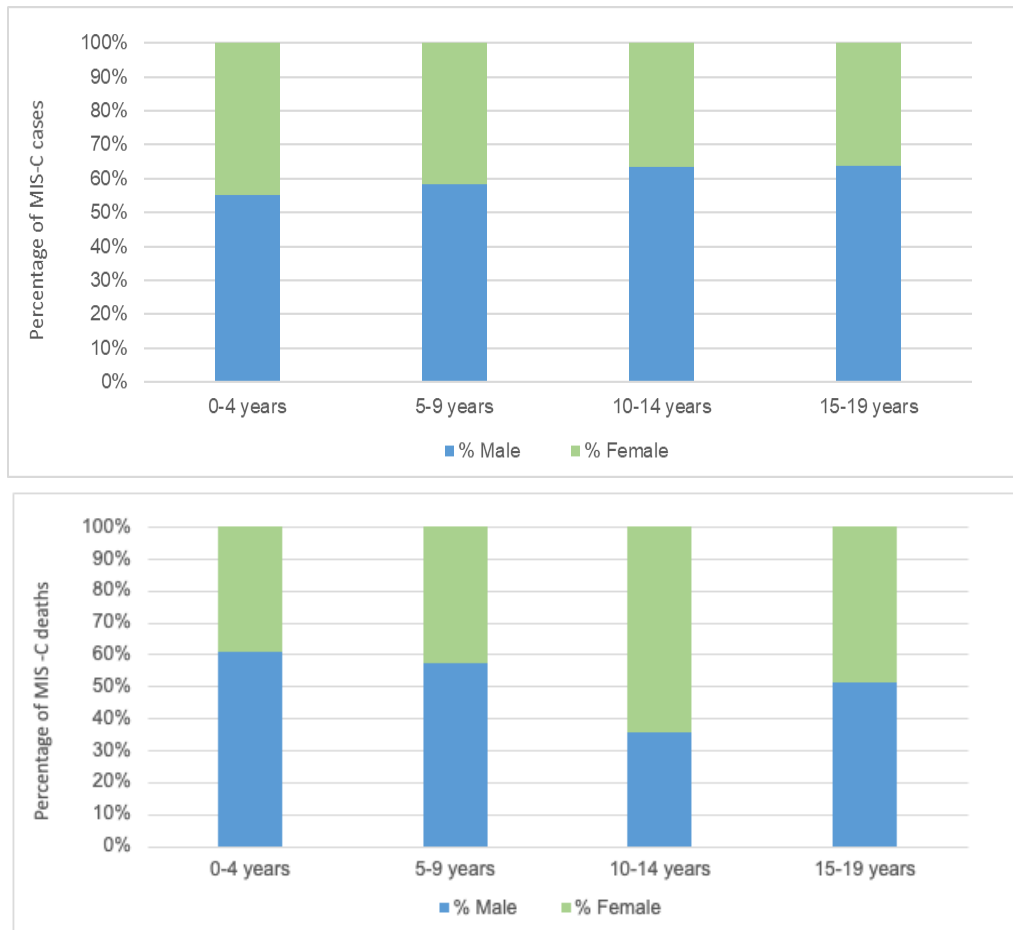
Of the total number of reported cases for which data on age and sex were available (n=7,758), the distribution of cases among age groups was 30% among 0 to 4 years, 33% among 5 to 9 years, 26% among 10 to 14 years, and 11% among 15 to 19 years (the United States of America includes 20-year-olds in this age group). Regarding the distribution by sex, 59% of the cases were male.

Among the 156 deaths for which data on age and sex were available, 33% were aged 0 to 4 years, 22% aged 5 to 9 years, 20% aged 10 to 14 years, and 25% aged 15 to 19 years. Regarding the distribution by sex, the gap between males and females is closer, with 53% of the deaths among males.

Among cases by age group and sex, the distribution of males versus females among 0 to 4-year-olds (55% male, 45% female) and 5 to 9-year-olds (58% male, 42% female) is lower than the overall distribution of MIS-C cases by sex (59% male, 41% female), while the distribution among 10 to 14-year-olds and 15 to 19-year-olds (64% male, 36% female, respectively) is higher, with approximately two-thirds of MIS-C cases occurring among males for each of these two age groups (**Figure 7a**).

Among deaths by age group and sex, the distribution of males versus females among 0 to 4-year-olds (61% male, 39% female) and 5 to 9-year-olds (57% male, 43% female) is higher than the overall distribution of MIS-C fatal cases by sex (53% male, 47% female) while the distribution among 15 to 19-year-olds (51% male, 49% female) generally aligns with the overall distribution observed in MIS-C cases. Conversely, among the 10 to 14-year-olds, the proportion among females is greater than males (35% male, 65% female). (**Figure 7b**). The potential factors contributing to these differences warrant further investigation and should continue to be monitored.

Figure 7a-b. Percentage of confirmed cases and deaths of multisystem inflammatory syndrome among children and adolescents (MIS-C) temporally related to COVID-19 in the Region of the Americas, by age group and sex. May 2020 to 29 October 2021*.



Notes: *29 October 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

According to the U.S. Centers for Disease Control and Prevention (CDC) website, data for the United States include 52 U.S. jurisdictions (including 49 states, New York City, Puerto Rico, and Washington, DC). Available at: <https://bit.ly/2SrKBOj>

Sources: Data provided by the International Health Regulations (IHR) National Focal Points (NFPs) or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

VII. COVID-19 among health workers

Since the first confirmed cases of COVID-19 were reported in the Region of the Americas and until 28 October 2021, at least 2,176,474 COVID-19 cases among health workers, including 11,840 deaths, have been reported according to the data made available by 41 countries and territories in the Americas (**Table 9**). This represents 167,794 additional cases and 788 additional deaths since the last PAHO/WHO Epidemiological Update on COVID-19, published on 27 September 2021.³ The total number of cases represents 14.5% of the estimated 15 million health workers in the Americas.²¹

²¹ PAHO/WHO. Weekly Press Briefing on COVID-19: Director's Opening Remarks, 12 May 2021. Available at: <https://bit.ly/3uEhbKC>

Table 9. Distribution of cumulative confirmed cases and deaths of COVID-19 among health workers in the Region of the Americas. January 2020 to 28 October 2021*.

Country/Territory	Number of confirmed cases of COVID-19	Number of deaths
Anguilla	10	0
Antigua and Barbuda	44	2
Argentina	99,036	617
Aruba	290	0
Bahamas	955	14
Belize	340	2
Bermuda	58	0
Bolivia	28,418	456
Bonaire	102	1
Brazil	654,724	894
British Virgin Islands	141	0
Canada	113,105	64
Cayman Islands	29	0
Chile	65,326	135
Colombia	67,152	335
Costa Rica	8,969	57
Curaçao	134	0
Dominica	1	0
Dominican Republic	1,409	22
Ecuador	13,332	156
El Salvador	7,643	79
Falkland Islands	12	0
Grenada	14	0
Guatemala	8,642	65
Haiti	781	3
Honduras**	13,668	115
Jamaica**	861	4
Mexico	282,036	4,497
Panama	8,657	112
Paraguay	17,722	183
Peru	75,536	1,471
Saint Kitts and Nevis**	34	0
Saint Lucia	213	0
Saint Vincent and the Grenadines	31	0
Sint Eustatius	8	0
Sint Maarten	64	0
Suriname	1,722	3
Turks and Caicos	108	0
United States of America	688,902	2,320
Uruguay	9,439	28
Venezuela	6,806	205
Total	2,176,474	11,840

Notes: * 28 October 2021 corresponds to the date of the most recent report received by PAHO/WHO; there may be differences in the dates that each country provided the last report to PAHO/WHO or published the report. Preliminary data subject to change based on retrospective investigation.

** No update since the PAHO/WHO Epidemiological Update on COVID 19, published on 27 September 2021³


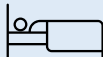





‡ The information Mexico presents corresponds to the occupation variable of the Epidemiological Surveillance System for Viral Respiratory Disease (SISVER). The analysis reflects cases reported performing a health-related occupation. It is important to clarify that the information collected in SISVER does not allow to identify if the contagion occurred in the workplace, at home or in the community; nor does it establish whether health personnel are currently working in a medical care unit.

Source: Data provided by the International Health Regulations (IHR) National Focal Points (NFPs) or published by the Ministries of Health, Institutes of Health, or similar health agencies and reproduced by PAHO/WHO.

Guidance for national authorities

PAHO/WHO continues to reiterate and update recommendations to support all Member States on management and protection measures for COVID-19 and reiterates the recommendations included in the PAHO/WHO Epidemiological Alerts and Updates on COVID-19 available at: <https://www.paho.org/en/epidemiological-alerts-and-updates>.

The following are guidance, scientific reports, and other resources published by PAHO/WHO and WHO.

<p>Surveillance, rapid response teams, and case investigation</p> 	<p>Clinical management</p> 
<p>WHO resources available at: https://bit.ly/30zjmCj</p> <p>PAHO/WHO resources available at: https://bit.ly/36DJi3B</p>	<p>WHO resources available at: https://bit.ly/3li6wQB</p> <p>PAHO/WHO resources available at: https://bit.ly/3sadTxQ</p>
<p>Laboratory</p> 	<p>Infection prevention and control</p> 
<p>WHO resources available at: https://bit.ly/3d3TJ1g</p> <p>PAHO/WHO resources available at: https://bit.ly/3oD2Qen</p>	<p>WHO resources available at: https://bit.ly/3d2ckuV</p> <p>PAHO/WHO resources available at: https://bit.ly/3nwyOaN</p>
<p>Critical preparedness and response</p> 	<p>Travel, Points of entry, and border health</p> 
<p>WHO resources available at: https://bit.ly/3ljWHBT</p> <p>PAHO/WHO resources available at: https://bit.ly/36DJi3B</p>	<p>WHO resources available at: https://bit.ly/3ivDivW</p> <p>PAHO/WHO resources available at: https://bit.ly/36DJi3B</p>
<p>Schools, workplaces, & other institutions</p> 	<p>Other resources</p>
<p>WHO resources available at: https://bit.ly/3d66iJO</p> <p>PAHO/WHO resources available at: https://bit.ly/36DJi3B</p>	<p>WHO resources available at: https://bit.ly/33zXgRQ</p> <p>PAHO/WHO resources available at: https://bit.ly/36DJi3B</p>

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9. Report by the **Costa Rica** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
10. Report by the **Dominican Republic** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
11. Report by the **Ecuador** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
12. Report by the **Guatemala** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
13. Report by the **Haiti** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
14. Report by the **Mexico** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
15. Report by the **Netherlands** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email
16. Report by the **Paraguay** International Health Regulations (IHR) National Focal Point (NFP), received by PAHO/WHO via email

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